

Aesthetic Interest Questionnaire

NAME: _____ TODAY'S DATE: _____

| CONCERNS | |
|--|---|
| What brought you to the clinic today? | If you could change anything, what would it be? |
| <p>Which areas would you like to improve?</p> <p>FACE</p> <p><input type="checkbox"/> Fine lines & wrinkles</p> <p><input type="checkbox"/> Sagging facial or neck skin</p> <p><input type="checkbox"/> Submental fullness (double chin)</p> <p><input type="checkbox"/> Facial volume loss (cheeks, under eyes)</p> <p><input type="checkbox"/> Droopy brows/eyelids</p> <p><input type="checkbox"/> Thin lips</p> <p><input type="checkbox"/> Aging mouth/smokers' lines</p> <p><input type="checkbox"/> Sparse eyelashes or brows</p> <p><input type="checkbox"/> Acne</p> <p><input type="checkbox"/> Acne scarring</p> <p><input type="checkbox"/> Enlarged pores</p> <p><input type="checkbox"/> Age spots/brown spots</p> <p><input type="checkbox"/> Facial blemishes/skin tags/milia (bumps)</p> <p><input type="checkbox"/> Facial redness</p> <p><input type="checkbox"/> Broken capillaries or facial veins</p> <p><input type="checkbox"/> Blotchy/uneven skin</p> <p><input type="checkbox"/> Unwanted facial hair</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> | <p>BODY</p> <p><input type="checkbox"/> Excess body fat</p> <p><input type="checkbox"/> Lack of muscle tone/definition</p> <p><input type="checkbox"/> Sagging body skin</p> <p><input type="checkbox"/> Spider veins on legs</p> <p><input type="checkbox"/> Nail fungus</p> <p><input type="checkbox"/> Moles and/or skin growths</p> <p><input type="checkbox"/> Surgical/facial scars</p> <p><input type="checkbox"/> Unwanted body hair</p> <p><input type="checkbox"/> Excessive underarm sweating</p> <p><input type="checkbox"/> Unwanted tattoo(s)</p> <p><input type="checkbox"/> Urine leakage with sneeze or cough</p> <p><input type="checkbox"/> Sudden urgency to urinate</p> <p><input type="checkbox"/> Other _____</p> <p>Would you be interested in a consultation with one of our body specialists? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>List key areas of interest:</p> |
| <p>Would you be interested in a make-up consultation? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>List key areas of interest:</p> | <p>Would you be interested in a skincare product consultation? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>List key areas of interest:</p> |

Today's Date: _____

PATIENT INFORMATION

| | | | | | |
|---|--------|--------------------------|--|---|---|
| Name: First | Middle | Last | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital status (circle one): Single/ Married/ Divorced / Separated / Widow / Partner |
| Street address: | | | Birth date: / / | | Age: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other |
| City: | | State: | ZIP Code: | | Best Contact: Cell __ Home __ Work __ () |
| Email: | | | | | Can we leave a message on best contact #? YES ____ NO ____ |
| Occupation: | | Employer: | | | Alt. number: Cell __ Home __ Work __ () |
| Emergency contact: | | Relationship to patient: | | | Emergency contact phone: () |
| Referred by: <input type="checkbox"/> Health care provider _____ <input type="checkbox"/> Family/Friend _____ | | | <input type="checkbox"/> Radio _____ <input type="checkbox"/> Internet (site) _____ <input type="checkbox"/> Other _____ | | |

MEDICAL/SKIN HISTORY

| | | | |
|---|--|--|---|
| Do you have any of the following-past or present? <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Blood thinners <input type="checkbox"/> Phlebitis/blood clots <input type="checkbox"/> Other blood disorders (list) _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease/conditions (list) _____ <input type="checkbox"/> Pacemaker <input type="checkbox"/> Internal defibrillator <input type="checkbox"/> Artificial joints/ortho hardware <input type="checkbox"/> Metal screws/plates/pins <input type="checkbox"/> Are you able to have an MRI? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Excessive hair growth <input type="checkbox"/> Ovarian cysts (PCOS) <input type="checkbox"/> Copper IUD (Paragard) <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Sleep problems <input type="checkbox"/> Severe needle phobia <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Eating disorders <input type="checkbox"/> Headaches <input type="checkbox"/> Epilepsy/seizures <input type="checkbox"/> Cold sores/Blisters <input type="checkbox"/> Past <input type="checkbox"/> Present (Where?) _____ | <input type="checkbox"/> Skin cancer <input type="checkbox"/> Melanoma <input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Actinic keratosis <input type="checkbox"/> Skin infections <input type="checkbox"/> Other infections (list) _____ <input type="checkbox"/> Acne <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Melasma <input type="checkbox"/> Vitiligo <input type="checkbox"/> Other skin conditions _____ <input type="checkbox"/> Serious injuries <input type="checkbox"/> Any cancer (list) _____ | <input type="checkbox"/> Glaucoma <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hepatitis <input type="checkbox"/> Autoimmune diseases (list) <input type="checkbox"/> Thyroid (high/low) <input type="checkbox"/> Lupus <input type="checkbox"/> Scleroderma <input type="checkbox"/> Severe allergies <input type="checkbox"/> Any other _____ <input type="checkbox"/> Other health conditions _____ <input type="checkbox"/> Do you leak urine when you cough, sneeze or exercise? <input type="checkbox"/> Do you have a sudden urge to urinate? |
|---|--|--|---|

MEDICATIONS/ALLERGIES

Current medications (please include prescriptions, supplements, vitamins, and over-the-counter products): _____

Do you have any allergies? ☐ Drug (list) _____

☐ Lidocaine ☐ Eggs ☐ Nuts ☐ Other (list) _____

Have you ever had a reaction to: ☐ Cosmetics ☐ Metals ☐ Food ☐ Fragrance ☐ Airborne particles ☐ Preservatives

Do you have food intolerance? ☐ No ☐ Yes (what?) _____

OTHER HEALTH INFO

Current Health Care Provider:

Dermatologist:

How would you describe your overall health? _____

Is your stress level? high medium low

Do you smoke? ☐ No ☐ Yes, Packs per day: _____

Alcohol use? ☐ No ☐ Rarely ☐ 2-3 per week ☐ 2-3 per day ☐

Other _____

Other recreational drugs? ☐ No ☐ Yes, Type: _____

What is your daily intake of water (cups)?

☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ more

How many cups of caffeine do you drink daily?

☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8 ☐ more

Do you exercise regularly? ☐ Yes ☐ No

If yes, do you cleanse after? ☐ Yes ☐ No

FOR WOMEN:

☐ Oral Contraceptives ☐ No ☐ Yes, Type: _____

☐ Pregnant

☐ Breastfeeding

☐ Hormone imbalances

☐ Menopause/Perimenopause

SKIN HISTORY

Do you cleanse your face? ☐ Morning ☐ Evening ☐ Other

How would you describe your skin?

☐ Normal ☐ Dry ☐ Oily ☐ Combination

☐ Sensitive ☐ Sun-Damaged

Do you blush easily? ☐ Yes ☐ No

If yes, what are the contributing factors?

☐ Emotions ☐ Foods/Drinks ☐ Temperature changes

☐ Alcohol ☐ Other

Do you Bruise easily? ☐ Yes ☐ No

Are you taking: ☐ Aspirin ☐ Ibuprofen ☐ Vitamin E ☐ Fish Oil

Do you swell easily? ☐ NO ☐ YES

How does your skin heal?

☐ Average

☐ Fast

☐ Slow

☐ Scar easily

☐ With pigment irregularities

☐ Develops keloids

Under treatment for any current skin condition? ☐ No ☐ Yes

What condition?

Do you wear foundation regularly? ☐ Yes ☐ No

If yes, ☐ Powder ☐ Liquid ☐ Cream

What type of skin care products do you use?

Do you ever experience:

☐ Flakiness ☐ Redness ☐ Tightness

☐ Excessive oily shine

Frequent sun exposure? ☐ Yes ☐ No ☐ Past ☐ Present

Do you use a tanning bed? ☐ Yes ☐ No ☐ Past ☐ Present

Exposure to chemicals, oils, or other caustic substances that may aggravate your skin. ☐ No ☐ Yes (what?)

Past or present use of?

☐ Accutane ☐ Retin-A ☐ Hydroquinone ☐ Topical antibiotics

☐ Oral antibiotics ☐ Differin ☐ Renova ☐ Alpha Hydroxy Acids

(AHA's) ☐ Metrogel ☐ Finacea ☐ Any topical prescriptions

For how long?

AESTHETIC HISTORY

Have you ever had these treatments in the past:

☐ Chemical Peels ☐ Microdermabrasion ☐ Dermal Fillers (ex. Juvederm, Restylane, Sculptra) ☐ Botox/Dysport ☐ Phototherapy (IPL/BBL)

☐ Laser Peels ☐ Laser Resurfacing (deep peel and/or fractional) ☐ SkinTyte/Thermage/Ultherapy ☐ Kybella ☐ Emsculpt ☐ CoolSculpting

☐ Plastic Surgery (date/type): _____

☐ Other procedures not mentioned (date/type): _____

SIGNATURE

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE (if under 18): _____ DATE: _____

Skin Typing Matrix

Name: _____

Date: _____

Please answer the following questions by circling the number which best describes you.

| | | |
|---|--|----------------------------------|
| My Ethnic origin is closest to: | Very fair (Celtic and Scandinavian) Fair-skinned Caucasian with light hair and light eyes Pale-skinned Caucasian with dark hair and dark eyes Olive-skinned (Mediterranean, some Asian, some Hispanic) Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans) Very dark-skinned (African) | -- -- -- -- -- -- |
| My eye color is: | Light blue Blue/Green Green/Gray/Golden Hazel/Light Brown Brown | 0 1 2 3 4 |
| My natural hair color at age 18 was: | Red Blonde Light brown Dark brown Black | 0 1 2 3 4 |
| The color of my skin that is not normally exposed to sun is: | Pink to reddish Very Pale Pale with a beige tan Light brown Medium to dark brown Dark brown to black | 0 1 2 3 4 5 |
| If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will: | Burn, blister and peel Burn, then when burn resolves there is little or no color change Burn, but then turns to tan in a few days Gets pink, but then turns to tan quickly Just tan Just gets darker My skin color is so dark I can't tell | 0 1 2 3 4 5 6 |
| When was the last time the area to be treated was exposed to natural sunlight, tanning booths, or artificial tanning cream? | Longer than one month ago Within the past month Within the past two weeks Within the past week | 0 1 2 3 |

| | |
|-------------------|--------------------|
| If your score is: | Your skin type is: |
| 0-3 | 1 |
| 4-7 | 2 |
| 8-11 | 3 |
| 12-15 | 4 |
| 16-19 | 5 |
| 20-24 | 6 |

Total _____

Additional questions:

- If you sustain an injury to your skin such as a cut, burn or bruise, how long does it take to fully resolve without any discoloration? _____
- What happens if you get an insect/mosquito bite? Do you feel you swell more than others?



24 Hour Appointment Cancellation Policy

We're so excited that you have an appointment with us! Your time slot has been chosen specifically for you so we hope you can make it. We require a minimum of 24 hours' notice to cancel or reschedule your appointment. If you no-show or cancel in less than 24 hours, **you will be charged a \$50 cancellation fee**. You will not be able to re-book another appointment until the fee is paid.

This policy is in place out of respect for our patients and providers. We have had a waiting list for some time now and even closed our practice to new consultations/patients in 2022. We understand this policy has not been enforced in the past but due to the high demand for timely appointments, we will be strictly enforcing this plan.

By signing below, you acknowledge that you have read and understand the cancellation policy for **Rejuvenation Clinic of Sauk Prairie** as described above.

Thank you for your understanding.

Name: _____ Date: _____